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c. The Individual Service Plan (ISP) must be developed or revised with 10 business days of the approved assessment or reassessment. The LMHP, certified prescreener, or QMHP shall develop the ISP.

d. Room and board, custodial care, and general supervision are not components of this service.

e. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

f. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.

g. Providers of crisis stabilization shall be licensed by DMHMRSAS as providers of outpatient services.

H. Mental health support services.

a. At admission, an appropriate face-to-face assessment must be made and documented by the LMNP or the QMHP, indicating that service needs can best be met through mental health support services. The assessment must be performed by the LMHP, or the QMHP and approved by the LMHP, within 30 days of the date of admission. The LMHP or the QMHP will complete the ISOP within 30 days of the date of admission. The LMHP or the QMHP will complete the ISP within 30 days of the admission to this service. The ISP must indicate the specific supports and services to be provided and the goals and objectives to be accomplished. The LMHP or QMNP will supervise the care if delivered by the qualified paraprofessional.

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b. Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP. The ISP must be rewritten at least annually.

c. Only direct face-to-face contacts and services to individuals shall be reimbursable.

d. Any services provided to the client that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

e. Any services provided to clients that are strictly vocational in nature shall not be billable. However, support activities and activities directly related to assisting a client to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in a overall work environment shall be billable.

f. Room and board, custodial care, and general supervision are not components of this service.

g. This service is not billable for individuals who reside in facilities where staff are expected to provide such services under facility licensure requirements.

h. Provider qualifications. The enrolled provider of mental health support services must be licensed by DMHMRSAS as a provider of supportive in-home services, Intensive Community Treatment, or as a program of Assertive Community Treatment. Individuals employed or contracted by the provider to provide mental health support services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.

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i. Mental health support services, which continue for six consecutive months, must be reviewed and renewed at the end of the six month period of authorization by an LMHP who must document the continued need for the services.

j. Mental health support services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided.

D. Mental retardation utilization criteria. *Repealed.*

E. Substance abuse treatment services utilization review criteria. (12 VAC 30-60-147)

1. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

a. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC 30-50-510.

(1) To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of

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the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

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c. Services for the individual must be preauthorized annually by DMHMRSAS.

d. Each individual must have a written plan of care developed by the provider which must be fully complete within 30 days of initiation of the service, with a review of the plan of care at least every 90 days with modification as appropriate. A 10-day grace period is allowable.

e. The provider must update the plan of care at least annually.

f. The individual's record must contain adequate documentation concerning progress or lack thereof in meeting plan of care goals.

g. The program must operate a minimum of two continuous hours in a 24-hour period. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be at least four but less than seven hours on a given day. Three units of service shall be defined as seven or more hours in a given day. Transportation time to and from the program site may be included as part of the reimbursable unit. However, transportation time exceeding 25% of the total daily time spent in the service for each individual shall not be covered. These restrictions shall apply only to transportation to and from the program site. Other program-related transportation may be included in the program day as indicated by scheduled program activities.

h. The provider must be licensed by DMHMRSAS.

2. Appropriate use of case management services for persons with mental retardation requires the following conditions to be met:

a. The individual must require case management as documented on the consumer service plan of care which is developed based on appropriate assessment and supporting data. Authorization for case management services must be obtained from DMHMRSAS Care Coordination Unit annually.

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b. An active client shall be defined as an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and other entities including a minimum of one face-to-face contact within a 90-day period.

c. The plan of care shall address the individual's needs in all life areas with consideration of the individual's age, primary disability, level of functioning and other relevant factors.

(1) The plan of care shall be reviewed by the case manager every three months to ensure the identified needs are met and the required services are provided. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be given up to the last day of the fourth month following the month of the prior review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of the actual review.

(2) The need for case management services shall be assessed and justified through the development of an annual consumer service plan.

d. The individual's record must contain adequate documentation concerning progress or lack thereof in meeting the consumer service plan goals.

E. Substance abuse treatment services utilization review criteria. (12 VAC 30-60-147)

1. Substance abuse residential treatment services for pregnant and postpartum women. This subsection provides for required services which must be provided to participants, linkages to other programs tailored to specific recipient needs, and program staff qualifications. The following services must be rendered to program participants and documented in their case files in order for this residential service to be reimbursed by Medicaid.

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a. Services must be authorized following face-to-face evaluation/diagnostic assessment conducted by one of the appropriately licensed or certified professionals as specified in 12VAC 30-50-510.

(1) To assess whether the woman will benefit from the treatment provided by this service, the professional shall utilize the Adult Patient Placement Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium/High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. Services must be reauthorized every 90 days by one of the appropriately authorized professionals, based on documented assessment using Adult Continued Service Criteria for Level III.3 (Clinically-Managed Medium-Intensity Residential Treatment) or Level III.5 (Clinically-Managed Medium-High Intensity Residential Treatment) as described in Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised 2001, published by the American Society of Addiction Medicine. In addition, services must be reauthorized by one of the authorized professionals if the patient is absent for more than 72 hours from the program without staff permission. All of the professionals must demonstrate competencies in the use of these criteria. The authorizing professional must not be the same individual providing nonmedical clinical supervision in the program.

(2) Utilization reviews shall verify, but not be limited to, the presence of these 90-day reauthorizations as well as the appropriate re-authorizations after absences.

(3) Documented assessment regarding the woman's need for the intense level of services must have occurred within 30 days prior to admission.

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(4) The Individual Service Plan (ISP) shall be developed within one week of admission and the obstetric assessment completed and documented within a two-week period following admission. Development of the ISP shall involve the woman, appropriate significant others, and representatives of appropriate service agencies.

(5) The ISP shall be reviewed and updated every two weeks.

(6) Psychological and psychiatric assessments, when appropriate, shall be completed within 30 days of admission.

(7) Face-to-face therapeutic contact with the woman which is directly related to her Individual Service Plan shall be documented at least twice per week.

(8) While the woman is participating in this substance abuse residential program, reimbursement shall not be made for any other community mental health/mental retardation/substance abuse rehabilitative services concurrently rendered to her.

(9) Documented discharge planning shall begin at least 60 days prior to the estimated date of delivery. If the service is initiated later than 60 days prior to the estimated date of delivery, discharge planning must begin within two weeks of admission. Discharge planning shall involve the woman, appropriate significant others, and representatives of appropriate service agencies. The priority services of discharge planning shall seek to assure a stable, sober, and drug-free environment and treatment supports for the woman.

b. Linkages to other services. Access to the following services shall be provided and documented in either the woman's record or the program documentation:

(1) The program must have a contractual relationship with an obstetrician/gynecologist who must be licensed by the Board of Medicine of the Virginia Department of Health Professions.

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(2) The program must also have a documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services for the woman and ongoing training and consultation to the staff of the program.

(3) In addition, the provider must provide access to the following services either through staff at the residential program or through contract:

(a) Psychiatric assessments as needed, which must be performed by a physician licensed to practice by the Virginia Board of Medicine.

(b) Psychological assessments as needed, which must be performed by a clinical psychologist licensed to practice by the Board of Psychology of the Virginia Department of Health Professions.

(c) Medication management as needed or at least quarterly for women in the program, which must be performed by a physician licensed to practice by the Board of Medicine in consultation with the high-risk pregnancy unit, if appropriate.

(d) Psychological treatment, as appropriate, for women present in the program, with clinical supervision provided by a clinical psychologist licensed to practice by the Board of Psychology.

(e) Primary health care, including routine gynecological and obstetrical care, if not already available to the women in the program through other means (e.g., Medallion or other Medicaid-sponsored primary health care program).

2. Program and staff qualifications. In order to be eligible for Medicaid reimbursement, the following minimum program and staff qualifications must be met:

a. The provider of treatment services shall be licensed by DMHMRSAS to provide residential substance abuse services.

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b. Nonmedical clinical supervision must be provided to staff at least weekly by one of the following professionals:

(1) A counselor who has completed master's level training in either psychology, social work, counseling or rehabilitation who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals of the Virginia Department of Health Professions or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

(2) A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, registered nurse, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

(3) A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master addiction counselor by the National Association of Alcoholism and Drug Abuse Counselors.

c. Residential facility capacity shall be limited to 16 adults. Dependent children who accompany the woman into the residential treatment facility and neonates born while the woman is in treatment shall not be included in the 16-bed capacity count. These children shall not receive any treatment for substance abuse or psychiatric disorders from the facility.

d. The minimum ratio of clinical staff to women should ensure that sufficient numbers of staff are available to adequately address the needs of the women in the program.